CHAPTER 9. MEDICAL MATERIEL READINESS

9-1. AGENCIES SUPPORTING MEDICAL MATERIEL READINESS

a. **MACOM** (FORSCOM/USARPAC-EUSA/USAREUR): Sourcing Unit MACOMs will provide Unit funding and identify requirements for all medical (SRC 08) Units under their commands. MACOMs are responsible for supporting the required Contingency Plan and OPLANs with Units that are adequately resourced to meet the warfighting combatant commander's requirements.

b. **USAMEDCOM/OTSG**: Programs, budgets, and executes central management of the CL VIII commodity, to include DA-funded, centrally managed programs (APS, MCDM, UDP, Installation Support Package) and commercial business interaction. They also provide the doctrine, regulations, and policy for the medical force.

c. **MRMC**: Serves to integrate the testing, research, and materiel developer to identify the future medical threat, treatment requirements, and provide the standardized support for MTOE organizations. MRMC commands the USAMMA and the USAMMCE. These two USAMEDCOM materiel agencies provide assembly management and other centrally-managed support to CONUS and OCONUS theaters.

d. **The USAMMA**: Serves as the designated central medical materiel manager for USAMEDCOM/OTSG. The USAMMA manages strategic and operational medical materiel programs that support MTOE Units in all components. Serves as the materiel developer for Army standardized sets.

e. **Medical Logistics Support Team (MLST)**: Represents the USAMMA capability to handoff APS and other TSG contingency stocks to deploying units falling in on APS. The MLST operates under the operational control of the Army Materiel Command's (AMC's) Logistics Support Element and IAW the command surgeon guidance.

f. **RMC**: RMCs shift assets to support major mobilization requirements and provide resource management and contracting support to adequately support installation and deploying Unit requirements at the direction of USAMEDCOM/OTSG. RMC directs IMSA actions to support mobilization, deployment, and redeployment activities.

g. **IMSA** [Power Projection Platform {PPP}/Power Support Platform {PSP}]: Provide direct support for all standard and non-standard requests for medical materiel and equipment maintenance.

(1) IMSAs will provide the following support for deploying units:

(a) The M3PT tool will provide a listing of all MES/MMS that each installation supports by building a scenario for all supported units. Once the scenario is built, run the unit assemblage report to produce all NSNs that must be mapped to a SOS part number.

(b) Establish accounts for COMPO 1 units and map shortages to available sources of supply. Maintain customer files either, electronic or paper for COMPO 1 units. These files will contain unit contact information, a log detailing interactions between the unit and IMSA, and a listing of all authorized CL VIII items

mapped to a source of supply part number with a record of this number built into the local MTF catalog.

(c) Maintain customer files either electronic or paper for COMPO 2/3 units. These files will contain unit contact information, a log detailing interactions between the unit and IMSA, and a listing of all authorized CL VIII items. The authorized CL VIII items are obtainable by running a unit assemblage listing in M3PT.

(2) Assist with storage and distribution of USAMEDCOM/OTSG centrally managed programs. Mobilization stations provide the support to deploy TO&E forces, fill deploying Units to meet Combatant Command (COCOM) force requirements, expansion of medical facilities and transition support to reserve elements to sustain the Mobilization station missions for continuing support through all phases of Army operations.

h. **DSCP**: Provide DLA/DoD interface for the CL VIII commodity. Provide commercial contracting and medical materiel support capability through the Defense Wide Working Capital Operating Fund.

i **MLMC**: Provides an automated Single Integrated Medical Logistics Manager (SIMLM) support function for the COCOM (CINC is no longer an operational term) collecting and providing detailed medical materiel management functions allowing real-time commodity management and feedback to the force provider to ensure complete logistics coverage for a theater of operations.

j **AMEDDC&S**: Develops the doctrine, validates the current standards of care, and trains the medical logistician. Additionally, AMEDD&S Coordinates the training and modernization of the medical force with other Services and within the DA.

k. The Directorate of Combat and Doctrine Development (**DCDD**) serves as the combat developer, integrating doctrine and standardizing requirements in conjunction with the expressed capability requirements of the combat force.

9-2. BACKGROUND ON MEDICAL MATERIEL READINESS

a. Class VIII materiel support for Army Units is divided into several categories:

(1) **Non-Unit Assemblage (UA) Materiel** (clinician or mission specific, non-standardized)

(2) **Non-Centrally Managed UA Materiel** (Unit funded, centrally standardized)

(3) **Centrally Managed** (the USAMMA and DSCP-managed, standardized)

(4) **Medical Chemical, Biological, Radiological, and Nuclear (CBRN) Defense Materiel (MCDM)**(OTSG-owned, USAMEDCOM/USAMMA-Managed)

(5) **Army Pre-Positioned Stocks** (APS – geographically distributed, DA-owned, USAMMA-managed)

(6) **Army Emergency First Responder Program** (AEFRP) and the joint **Installation Protection Program** (IPP) (USAMEDCOM owned and managed)

(7) **Radioprotectants** (DoD owned)

b. The USAMMA is responsible for the initial fielding of the MMS and MESs that comprise a Unit Basic Load (UBL). These SKOs are currently fielded as outlined in *AR 40-61*. The IMSA is the source of supply to fill Unit-generated shortages (consumed items, Unit assemblage updates, expired items, and field losses) for all

Units. In order to maintain readiness, all supplies must be on hand, on order, or part of a pre-arranged agreement where previously identified items may be obtained through Prime Vendors or other contract sources. Based upon unit deployment timelines, it is the unit's responsibility to maintain their basic load, unless covered by a centrally managed program. Units must submit funded requisitions to procure these items. The IMSA will map requirements to ensure that there is a viable acquisition tool in place to procure these items. The Unit is required to make annual coordination with the IMSA to identify shortages and coordinate sources of supply.

c. All medical Units must coordinate their requirements for medical materiel to their supporting IMSAs annually. Reserve Units will maintain only the non-expendable and durable components of their UBL. The IMSA will be the source of supply to acquire the Class VIII expendable UBL items to support Reserve Component (RC) Units upon mobilization. The IMSA will match these requirements to a source of supply to ensure rapid acquisition. All Units will validate that the acquisition timeline supports their wartime mobilization mission.

d. Managed Materiel

(1) Non Centrally Managed: Division And Below (DAB) Units must maintain their basic loads and fill Unit generated shortages, UA updates, and mission-specific items. Commanders will maintain Unit Assemblages (UAs) per guidance in this SB 8-75-11, Chapter 10. The AMEDD does not centrally manage materiel for active component divisional Units. DAB medical units are expected to deploy with their entire Class VIII UBL.

(2) Centrally Managed: For rapid deployment/contingencies, however, DA Deputy Chief of Staff Operations may identify and direct that a DAB Unit will be supported by centrally managed Brigade sets from APS (reference SB 8-75-S7 dated 20 July 2006). These directions will be published in the applicable Operations Order (OPORD).

e. The USAMMA centrally manages Class VIII materiel for early deploying Active and Reserve Medical Units at the level above Division. This materiel serves as initial deployment medical UBL for deploying Units. The materiel contained in this program is identified in the SB 8-75-S7. The USAMMA, USAMEDCOM, and the deploying Unit will coordinate for acquisition and hand off of class VIII materiel in a contingency. The MLST is the medical materiel hand-off team that is an integral part of the Army Materiel Command Logistics Support Element (LSE). The MLST will hand off Class VIII Unit Deployment Packages (UDP) and APS as directed by the USAMMA in coordinated effort with the deploying Unit.

9-3. COMMON READINESS MATERIEL ITEMS

CTA 8-100 is the source for all deployable Unit common medical items (Chap Stick™, foot powder, first-aid kits, etc.). These items are requested through the supporting IMSA. CTA 8-100 provides a basic guideline for the quantity of items to order for a given Unit. Unit supply personnel order these items using OMA funds.

a. Combat Lifesaver (CLS) Bags/Training: These are service-regulated items. They are ordered through the supporting IMSA with a justification memorandum attached detailing the personnel who will receive the MES, and their current training qualification. Only currently certified CLS personnel will receive the MES. Units will store the controlled components of CLS bags to prevent misuse IAW *AR 190-51* (Unit

safe, with designated/controlled access; inventoried quarterly). MES CLS is accounted for as a durable item and hand receipted to the user level.

b. Patient Movement Items (PMI): PMIs are initially issued with SKOs to Units identified during contingency operations. Replenishments are done by line-item requisition or direct exchange on a one-for-one basis with other Units during patient transfer. PMIs are service-certified for Air-Worthiness Standards based on Service specific airframes and intended to be used on the service associated evacuation platforms. Hand receipted durable items are accounted for by item, not serial number or other marking method. Non-expendables are controlled by serial number except where transferred for patient evacuation (ambulance exchange).

c. Moulage: Casualty simulation sets, or moulage sets, are CTA-authorized items. Typically, the supporting installation Training Aid Support Center will maintain sets for use. Otherwise, Units will order the sets according to CTA 8-100 through their servicing IMSA. The sets are durable items and replenished by line item requisition.

9-4. LEVELS OF SUPPORT FOR MEDICAL MATERIEL READINESS

a. Division Units: For Units in Divisions, Regiments, and Separate Brigades, medical materiel support is provided by the Division/Brigade/Regiment Surgeon's Office via either the Division Medical Operations Center/DMSO (legacy system) or the Division Materiel Management Center (DMMC) Medical Supply section (current system). Medical materiel in combat units is highly standardized, decentralized (controlled and managed by operational funds at the lowest level), and sustained by the owning Unit.

(1) Fielding of UBL: Units are fielded their MESs and other authorized medical items by the USAMMA. The USAMMA Fielding Team conducts scheduled fieldings of Unit MES and other centrally managed SKOs within the Division. The USAMMA provides a one-time fielding for the SKO and upon completion of fielding, transfers accountability to the Unit to maintain and provide status on the SKO through command channels.

(2) Unit shortages/Sustainment of UBL: Units are funded and expected to maintain their sets to the highest level of fill to ensure readiness of the sets. Initial fielding shortages are filled by follow on ship short packages or direct funding to the Unit to order locally to fill any SKO shortages. Sustainment of the sets is the responsibility of the Unit commander and Division Surgeon (DS). Units will have materiel available within 72 hours. This means that materiel will either be accounted for as on hand, on order with a valid status, or directly available from the source of supply (for unfunded requirements). Units will validate annually through their source of supply (DMSO, DMMC, and IMSA) the availability of all materiel requirements that are currently not on hand. Sets with specialty items (Chemical Patient Decontamination) or short shelf-life items (Field Laboratory) will be closely managed to avoid expiration of vital components.

(3) The MCDM:

(a) Deployable Force Package assets of MCDM are centrally managed to support initial issue Individual Service Member requirements for Army personnel deploying to high threat areas. See SB-8-75-S7 for details on management and release of this matereil.

(b) MES, Chemical Agent Patient Trmt, LIN: M23673 Potency and Dated (P&D) items are centrally managed for early deploying units plus forward deployed, See SB-8-75-S7 for detail on management and release of this materiel.

(4) Mobilization/deployment instructions: Upon deployment or mobilization notification, Units will validate their deployment CL VIII DODAAC and order all shortages from the supporting IMSA/SSA for receipt and packaging. Unit UBL is typically considered To Accompany Troops (TAT) and loaded with other Unit equipment. It is essential that these Units deploy with 100 percent of the required capability as sustainment is based upon that planning assumption.

b. Levels Above Division: For Corps and higher level units, the typical structure of a Medical Brigade or Command will have medical logistics elements specifically designated to support the medical materiel and equipment requirements for those Units. Unit medical supply personnel will integrate via automated systems into the MEDLOG Company Combat Automated Support Server - Medical system to order shortages and validate status. Units will order and maintain their basic load except where covered by a centrally managed program as discussed below. Where Units are not supported in garrison by their MEDLOG Company, they will maintain active accounts with their IMSA for all deployment and training CL VIII requirements.

(1) Fielding of UBL: the process for these Units is essentially the same as Divisional Units; the key difference for selected early deploying (D-Day through D+30) EAD Units is the coverage by UDP for various Unit types (see SB 8-75-S7 dated 20 July 2006). For Units covered by UDP, only select materiel is fielded to accompany the non-expendable and durable ARC N and D components of Medical SKOs. Potency and Dated items between 1 and 60 months of shelf life are centrally managed in the UDPs associated with those Units, and the Units are not required to maintain or sustain those lines. For Units not covered by a UDP, the requirement for those Units is no different from Divisional Units – maintain sets to 100 percent on hand, on order, or validated as available from the local source of supply.

(2) Unit shortages/Sustainment of UBL: Units covered by UDP will maintain only designated “non UDP” covered lines at 100 percent fill. Units not covered by UDP will maintain highest level of fill funded and validate all unfunded requirements through source of supply to ensure acquisition capability subsequent to deployment funding supplements or project codes.

(3) MCDM: Units will draw/issue/turn-in their MCDM in the same manner as Divisional Units. Hospitals with a DS support requirement will also order and distribute MCDM in accordance with their DS support instructions. (For example, a CSH that supports three (3) Forward Surgical Teams (FSTs), provides MCDM and other supply support).

(4) Mobilization/deployment instructions: Per SB 8-75-S7, Units supported by UDP will maintain current contact information with the USAMMA and support fielding and issue plans for that materiel. Except for early deploying Units falling in on APS (UDP and other items), Units will plan and coordinate the transportation of CL VIII through their ITO. The level above Division medical units is typically more diverse than Divisional Units, and acquisition strategies to cover the greater range of requirements must occur annually between the IMSA and the unit.

(5) Redeployment: Units redeploying will either conduct a transfer of centrally-managed assets to the relieving Unit (in place) or turn in the centrally-managed assets to the supporting Medical Logistics Unit for return to centrally managed programs. Retention of those centrally managed assets requires further accountability by those Units until they turn-in those items.

c. MTOE Hospitals (Active Component): Medical Force 2000 and Medical Reengineering Initiative hospitals represent the Level 3 and 4 [North Atlantic Treaty Organization (NATO) Role 3] requirements for surgical stabilization and intensive care management of casualties. They also provide direct support for subordinate assigned and attached units, and Area Support for medical logistics when not co-located with MEDLOG Detachments or Companies.

(1) Fielding of UBL: The USAMMA provides centralized fielding and modernization of MTOE hospitals. Units are fielded to the current Program Objective Memorandum budget for that year, typically resulting in a 90 percent fill of non-UDP covered MMS and MESs. Additionally, APS cover early strategic hospitalization requirements due to the large transportation requirement required to move Hospitals.

(2) Unit shortages/Sustainment of UBL: Units are expected to maintain the fielded level of fill for their sets regardless of their designation as an early deployer (required to fall in on APS).

(3) MCDM: Units will draw/issue/turn-in their MCDM in the same manner as Divisional Units. Hospitals with a DS support requirement will order and distribute MCDM in accordance with their DS support instructions. (For example, a CSH that supports three FSTs will provide MCDM and other supply support.)

(4) Mobilization/ deployment instructions: Upon confirmation of deployment orders, the designated Unit will either receive augmentation in the form of UDP at mobilization station (assisted by the USAMMA Materiel Fielding Team {MFT}) if they are deploying with the first thirty (30 days) or (for early deploying Units) move via airlift (TAT only) and fall in on APS (assisted by the USAMMA MLST).

d. MTOE Hospitals (Reserve Component)

(1) Fielding of Mission Essential Equipment Training (MEET) sets: MEET sets are the non-expendable and durable components of selected MMS modules that make up a reserve hospital. MEET sets allow reserve hospital commanders the opportunity to perform the major tasks of setting up (complexing) hospitals and establishing the physical layout without buying and maintaining a vast amount of potency dated or maintainable items. MEET sets are fielded by the USAMMA to reserve component medical hospitals. Units conducting normal Reserve training drill or annual training are expected to purchase expendable components with training funds to make the MEET sets capable of supporting training objectives.

(2) Reserve Component Hospital Decrement (RCHD) Program: RCHD augments the MEET sets to fill out the remaining requirements to make the hospital fully operational for mobilization and deployment. RCHD assets are stored at Sierra Army Depot and fielded to the Unit at the mobilization station. The Unit and the USAMMA MFT field RCHD.

(3) MCDM: Units will draw/issue/turn-in their MCDM in the same manner as Divisional Units. Hospitals with DS requirements will support in the same manner as Active MTOE hospitals.

(4) Mobilization/deployment instructions: Upon receipt of an alert order, Unit Reserve Support Center liaisons should initiate contact with the OTSG to begin the process of identifying the Unit RCHD requirements to augment MEET sets. Reserve Units, deploying after D+30, are expected to bring their full equipment load to the mobilization station, to further augment with RCHD to the full capacity of their respective MTOE strength. Units will also receive any supporting UDPs at this time and flow with full equipment. Selected Reserve Units may fall in on active component sets that were released by Active APS supported hospitals.

(5) Re-deployment: RC Units will redeploy with their equipment. Federal Law requires that RC Units maintain accountability within their component – meaning

that Active Component (AC) Units cannot fall in on RC equipment unless they exchange equipment or receive exception consideration from DA G-3/G-4 via sourcing MACOM FORSCOM, USARPAC/EUSA, and USAREUR]. Upon redeployment, Units will return RCHD elements to the RCHD program with assistance from the USAMMA MLST or MFT.

e. All Units

(1) COMPO 1 Units will establish, at a minimum, an account with valid Assumption of Command orders and current DA 1687-Delegation of Authority Signature Card. Units will provide a copy of their CL VIII shortages.

(2) COMPO 2/3 units will provide valid unit contact information. This information should include at a minimum, unit name, Commander's name, address, phone number, email address of medical supply POC. This information must be updated biennially or upon unit relocation.

(3) Units are expected to maintain the highest level of readiness for which they are funded. Units are expected to deploy at greater than 90 percent of MTOE required strength for equipment in order to be certified by an installation commander.

(4) Units will receive applicable centrally managed materiel (typically MCDM) upon receipt of valid deployment orders or by Surgeon General directed and approved release (contingency support requirements).

9-5. MEDICAL CHEMICAL, BIOLOGICAL, RADIOLOGICAL, AND NUCLEAR (CBRN), DEFENSE MATERIEL (MCDM)

MCDM is centrally managed by the OTSG and executed by the USAMMA. See SB-8-75-S7 for details on management and release of this materiel.

9-6. ARMY EMERGENCY FIRST RESPONDER PROGRAM AND THE INSTALLATION PROTECTION PROGRAM

a. The Army Emergency First Responder Program (AEFRP) and the joint Installation Protection Program (IPP) provide CBRN pharmaceutical countermeasures (CPCs)to protect and treat emergency first responders and mission critical personnel who are exposed to CBRN agents, as a result of a CBRN incident on a installation.
b. Procedures for managing this materiel are still being developed. Draft guidance has been sent to the RMC. Final procedures will be published as an addendum in a future SB.

9-7. RADIOPROTECTANTS

a. The Radioprotectants are pharmaceutical countermeasures for use after an nuclear incident.

b. Procedures for managing this materiel are still being developed. Final procedures will be published as an addendum in a future SB.

9-8. MEDICAL MATERIEL READINESS SPECIAL CONSIDERATIONS

These categories of items require special attention and management beyond what has been addressed previously. Additionally, these are specific readiness items that

affect Unit deployments and sustainment due to acquisition restrictions and distribution controls that are not regulated by USAMEDCOM/OTSG policies. (Controlled substances are discussed in other chapters of *AR 40-61* and *AR 190-51*.)

a. Lab Reagents: Lab reagents are characterized by three important factors:

Limited Shelf Life	**Temperature Regulation**	**Limited Commercial Production**

As such, laboratory reagents are typically acquired by either local purchase or utilizing DSCP E-CAT web ordering tool from a vendor. Lab reagents may have long lead times for acquisition utilizing standard ordering procedures. The expected means of acquiring these items is through utilization of the DSCP ESOC for deploying and deployed medical Units requiring lab reagent support.

b. Cold Chain management: Temperature controlled (cold storage and frozen items) requires specific transportation controls to ensure that they maintain their viability between source and patient delivery. For items requiring cold chain management functions, the supporting SIMLM or the USAMMA Distribution Operations Center (under the USAMMA Force Sustainment Directorate) will support all packing and transportation instructions to ensure that adequate cold chain management measures are performed. Suspect medical materiel will be segregated and reported using Medical/Dental Product Quality Deficiency Report (M/DPQDR)--formerly SF380--Medical Complaint procedures to prevent patient injury or death.

c. Hazardous Materiel (HAZMAT): HAZMAT will be transported according to DOT and DoD requirements for safe movement. HAZMAT will be stored according to specific storage instructions for each item and category of HAZMAT. Additionally, applicable MSDS and other OSHA requirements will accompany all HAZMAT items for storage, shipment, and usage. HAZMAT is packed and shipped separate from other supplies and equipment and specific instructions on handling will be clearly marked on each package or container. Personnel who handle HAZMAT will be certified according to MACOM and OSHA requirements before transporting, packing, or handling HAZMAT items.

9-9. OCONUS MEDICAL LOGISTICS SUPPORT

a. **USAMMCE**: This TDA organization serves as the SIMLM for European Command, Africa, and South West Asia (SWA). Provides medical materiel management, depot level medical maintenance, and multi-vision optical fabrication for all services.

b. **16th MEDLOG BN**: This TDA-augmented MTOE organization serves as the SIMLM for Korea. Provides medical materiel management, GS medical maintenance, and multi-vision optical fabrication for all services on the Korean peninsula.

c. **226 MEDLOG BN**: Provides Medical Logistics support to European units and ongoing contingency operations throughout the European theater.

9-10. SOLDIER READINESS PROCESSING (SRP)

a. The USAMEDCOM responsibility for SRP/Predeployment Processing (PDP) is to provide screening checks for medical, dental, and visual readiness. Personnel are given updated medical examinations, dental examinations, vaccinations, eye examinations and medical appointments to ensure that all necessary standards of fitness are achieved prior to deployment. IMSAs are funded to provide those basic services and are coordinated by the hosting installation for Unit SRP functions.

b. Supplies are ordered from the supporting IMSA and paid for by that activity for all SRP requirements.

(1) Theater prophylactic requirements are defined by the sourcing and requiring commands. Vaccinations and other forms of prophylaxis are distributed prior to deployment and managed by the Unit surgeon for continued treatment upon deployment. Personnel medical records are updated during SRP to show initial vaccination and issue of prophylactic medicines.

(2) Optical devices will be prescribed and issued prior to deployment of personnel from the Mobilization station. The basic requirement will be one pair standard eyewear and one protective mask insert, one combat eye protection insert and one Land Operations (LO) frame for those personnel who meet the vision readiness requirement for corrective eyewear as determined by competent medical authority.